



Patient information

Patient Name: _____ DOB: _____
 Sex: Female Male SS #: _____
 1° Language: _____ Wt: _____ kg lbs Ht: _____ cm in
 Address: _____
 Apt/Suite: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alternate Phone: _____
 Caregiver name: _____ Relation: _____
 Local Pharmacy: _____ Phone: _____
 Insurance Plan: _____ Plan ID #: _____

Prescriber + shipping information

Prescriber Name: _____
 NPI #: _____
 Address: _____
 Apt/Suite # _____ City: _____ State: _____ Zip: _____
 Contact: _____
 Phone: _____ Alternate: _____
 Fax: _____
 Email address: _____
 If shipping to prescriber: 1st Month Always Never

Please fax a copy of front and back of the insurance card(s).

Clinical information (Please fax all pertinent clinical and lab information)

Diagnosis/ICD-10 (C00-D49): _____
 Patient Type (if applicable):
 adult female NOT of reproductive potential child female NOT of reproductive potential Date: _____
 adult female of reproductive potential child female of reproductive potential
 BRAF mutation present (if applicable): V600E V600K Any prior treatment: No Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Prescription

<input type="checkbox"/> Cotellic™ Three 20 mg tablets (60 mg) for 21 days on, 7 days off Quantity: 63 tablets Refills: _____ <input type="checkbox"/> Zelboraf® Four 240 mg tablets (960 mg) every 12 hours Quantity: 240 tablets Refills: _____	<input type="checkbox"/> Lonsurf® <input type="checkbox"/> 15 mg/6.14 mg Quantity: _____ Refills: _____ <input type="checkbox"/> 20 mg/8.19 mg Quantity: _____ Refills: _____ Take _____ mg (35 mg/m ² /dose) twice daily on days 1 through 5 and 8 through 12 for each 28-day cycle within one hour of completion of morning and evening meals (round to the closest 5 mg).
<input type="checkbox"/> Ibrance® <input type="checkbox"/> 100 mg tablet with food for 21 days on, 7 days off <input type="checkbox"/> 125 mg tablet with food for 21 days on, 7 days off Quantity: 21 tablets Refills: _____ with letrozole One 2.5 mg tablet once daily. Quantity: 28 tablets Refills: _____	<input type="checkbox"/> Ninlaro® One 4 mg cap daily on days 1, 8 and 15 of a 28-day cycle Quantity: 3 capsules Refills: _____ <input type="checkbox"/> Revlimid® One 25 mg cap for 21 days on, 7 days off Quantity: 21 capsules Refills: _____ <input type="checkbox"/> dexamethasone One 40 mg cap daily on days 1, 8, 15 and 22 of a 28-day cycle Quantity: 4 capsules Refills: _____ <input type="checkbox"/> Zytiga® Four 250 mg tablets (1000 mg) once daily without food Quantity: 120 tablets Refills: _____ with prednisone One 5 mg twice daily with food Quantity: 60 tablets Refills: _____

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|---|--|---|---|--|---|---|
| <input type="checkbox"/> Afinitor® | <input type="checkbox"/> Exjade®* | <input type="checkbox"/> Inlyta® | <input type="checkbox"/> Odomzo® | <input type="checkbox"/> Sylatron® | <input type="checkbox"/> Temodar® | <input type="checkbox"/> Xtandi® |
| <input type="checkbox"/> Afinitor® Disperz | <input type="checkbox"/> Farydak® | <input type="checkbox"/> Iressa® | <input type="checkbox"/> Pomalyst®** | <input type="checkbox"/> Tafinlar® | <input type="checkbox"/> Thalomid®** | <input type="checkbox"/> Zelboraf® |
| <input type="checkbox"/> Arimedex® | <input type="checkbox"/> Femara® | <input type="checkbox"/> Jadenu® | <input type="checkbox"/> Revlimid®** | <input type="checkbox"/> Tagrisso™ | <input type="checkbox"/> Tykerb® | <input type="checkbox"/> Zolinza® |
| <input type="checkbox"/> Bosulif® | <input type="checkbox"/> Gleevec® | <input type="checkbox"/> Jakafi® | <input type="checkbox"/> Sprycel® | <input type="checkbox"/> Tamoxifen® | <input type="checkbox"/> Votrient® | <input type="checkbox"/> Zykadia™ |
| <input type="checkbox"/> Cometriq® | <input type="checkbox"/> Hycamtin® | <input type="checkbox"/> Mekinist® | <input type="checkbox"/> Sutent® | <input type="checkbox"/> Tarceva® | <input type="checkbox"/> Xalkori® | <input type="checkbox"/> Zydelig™ |
| <input type="checkbox"/> Erivedge® | <input type="checkbox"/> Imbruvica™ | <input type="checkbox"/> Nexavar® | <input type="checkbox"/> Stivarga® | <input type="checkbox"/> Tasigna® | <input type="checkbox"/> Xeloda® | <input type="checkbox"/> _____ |

Strength(s): _____ Directions: _____
 Quantity: _____ Refills: _____ **Authorization: _____
 Packaging: Normal ***Exjade® Prescriptions (Fax ALL EPASS forms to 305.221.3275)**

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____
I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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